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linois Department of Public Health

_ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 03/23/16

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

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| exchanged positions with another CNA. During this period, the resident attempted self transfer back to wheelchair and fell." The documented corrective action is "Staff education provided related to Fall Management policy and Fall Prevention Program." "10/8/15, 10:00 PM, resident observed sitting on blue mat beside bed on buttocks, back against bed, legs extended out. (R2) had moderate amount of urine on floor/mat. When questioned, resident stated he slid off the side of the bed using his left arm to catch himself. Complaining of left shoulder pain." The documented causative factor is "Resident was found sitting on mat next to bed after alarm sounded. Resident stated he slid off side of bed when attempting to transfer and ambulate to the bathroom." The | \$999 | "8/8/15, 1:50 PM, R began to stumble, la injury." The docume "Upon investigation, was laying in bed w The resident prefers when in bed. The resident is not stead self. The resident state and the resident is not stead self. The resident state and the resident is "P Reoccurrence" is "V leave pants on the resident was educated "9/10/15, 12:00 PM, a Certified Nurse's A next CNA went in to was on the floor. He knees." The docume "Resident transferre wheelchair to toilet, exchanged positions this period, the resident to Fall Manar Prevention Program "10/8/15, 10:00 PM, blue mat beside bed amount of urine on fresident stated he slusing his left arm to of left shoulder pain. factor is "Resident w to bed after alarm so slid off side of bed w | esident was standing in room, anded on both knees, no ented contributing factor is. I learned that the resident ith a shirt and a diaper on. Is to have pants on as well esident was attempting to get ed, to get his pants. The dry and is unable to transfer umbled and fell to the floor." I lan of Action to Prevent We added to the care plan to esident while laying in bed. On this new process." Resident was on toilet when adde (CNA) came out and the cover the leaving CNA. (R2) stated that he landed on his ented causative factor is d with staff assistance from this staff member then a with another CNA. During lent attempted self transfer and fell." The documented Staff education provided gement policy and Fall." resident observed sitting on on buttocks, back against but. (R2) had moderate loor/mat. When questioned, id off the side of the bed catch himself. Complaining "The documented causative as found sitting on mat next bunded. Resident stated he hen attempting to transfer | S9999 | | | |

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| | documented "Plan of Reoccurrence" is "F will assist resident to | Prior to night shift change staff | | | | |
| | out of wheelchair wi the floor." The docu this fall is "Upon sta floor. Resident claim Resident is a feeder supervision and ass The documented co "Staff will assist resi | If, resident attempting to get thout assistance and fell to umented causative factor for nding, the resident fell to the ned to be ready for lunch, and requires staff istance to the dining room." Interctive action for this fall is dent to the wheelchair at the ady to be served in the dining | | | | |
| | the bed into the whe safety mat on the flo push the chair backy documented causati attempted self trans wheelchair. The whe mat next to the bed. resident attempted to the wheelchair to tilt documented correct will be placed next to | resident self transferred from selchair, which was on the sor. Resident attempted to wards and fell." The sive factor is "Resident fer from the bed into the selchair was on the safety. Once in the chair the opush it backwards causing and resident to fall." The sive action is "The wheelchair of the wall in the resident's ue with the floor safety mat | | | | |
| | the toilet. Alarm sour was found on floor in bumped head. No in corrective action for be placed on (R2's) I | (R2) attempting to put self on nded three times. Resident bathroom. States he jury noted." The documented this fall is "A door alarm will bathroom door." (R2's) chair was on blue pad | | | | |
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| environmental factors; R2's toileting schedule, how medication may have contributed to the falls | Militaria de la compania de la comp |
| Corporate Registered Nurse (RN) and previous Director of Nursing (DON), confirmed on 3/2/16 at 11:55 AM that the Facility failed to assess for potential causative factors and take corrective action based on those factors when reviewing R2's falls. E3 also confirmed that R2 should not have been left alone on the toilet by the CNA's, while they switched locations, on 9/10/15. R2 was originally admitted to the Facility on 3/3/15 with diagnoses, in part, of Parkinson's Disease, Malignant Neoplasm of the Bladder and Dementia. R2's Minimum Data Set (MDS), dated 6/10/15, documents that R2 had short and long term memory problems; was frequently incontinent of urine and occasionally incontinent of bowel; was not on a toileting program; and required the limited physical assistance of one person for transfers, ambulation and activities of daily living. R2's MDS, dated 7/16/15, documents that R2 had short and long term memory problems; was frequently incontinent of urine and occasionally incontinent of bowel; was not on a toileting program; and required the Extensive physical assistance of one person for transfers, ambulation, toilet use and activities of daily living. R2's MDS, dated 10/16/15, documents that R2 still required the extensive physical assistance of reapsfers, cibiet use, ambulating in his room, and activities of daily living. The MDS documents that R2 was not on a toileting | |

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| | not steady while mo standing position, w moving on and off th surface-to-surface to R2's plan of care, wi documents a "Focus falls related to unaw Documented interve "7/8/15, one-on-one to urinary urgency. 7 wheelchair. 8/8/15, pdown. 10/25/15, doo 12/28/15, staff to toil then prior to laying down, offer toilet ass R2's plan of care als "Functional Bladder tumor)." On 3/2/16 at 12:25 F that R2 was not on a while he lived in the pattern due to his urg care documenting to and then prior to laying laying him down, offer evening." R2's "Physician's Ord Seroquel, dated 7/6/mouth at bedtime. T (D/C) on 7/27/15. The documents the follow Seroquel: confusion, unusual drowsiness. | ving from a seated to alking, turning around, he toilet and ransfers. ith a start date of 3/4/15, is that "(R2) is at high risk for are of safety needs." intions for this "Focus" include as needed when restless due (7/23/15, seat belt alarm in bants on when he is laid in alarm to bathroom door. et prior to evening meal and own. 1 hour after laying him sist again in the evening." o documents a "Focus" of Incontinence (history of Incontinence | S9999 | | | |
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| | Sinemet until he exp MD website docume dizziness and lighth a sitting or lying posi There are no baselir readings documente Corporate Registerd Director of Nursing (11:55 AM that the Fa baseline orthostatic l nor did they assess if any of R2's falls. The Facility "Fall Mar "It is the policy of the Prevention Program resident in the facility program will include the individual needs assessing the risk of appropriate intervent supervision and assis necessary." The Fac risk of falls and imple interventions for R2. | ceiving the same dosage of bired on 1/20/16. The Web ents side effect for Sinemet as readedness when rising from ition. The orthostatic hypptension and in R2's clinical record. E3, Nurse (RN) and previous DON), confirmed on 3/2/16 at acility did not conduct hypotension readings for R2 for postural hypotension after agement policy documents facility to have a Fall to assure the safety of all to assure the safety of all to when possible. The measures which determine of each resident by falls and implementation of ions to provide necessary stive devices are utilized as cility failed to assess for the | S9999 | | | |

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: INTEGRITY HEALTH CARE OF CHESTER
DATE AND TYPE OF SURVEY: MARCH 8, 2016 - COMPLAINT #1641063/IL83661

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Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies shall be followed in operating the facility.

Section 300.1210 General Requirements for Nursing and Personal Care

- b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
- d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
- 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
- 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

Attachment B
Imposed Plan of Correction

This will be accomplished by:

- I. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident legal representative and family member when there is an accident involving the resident which has the potential for requiring physician intervention; a significant change in the resident condition (physical, mental, or psychosocial status i.e., deterioration in health, mental, or psychosocial in either life threatening conditions or clinical complications); a need to alter treatment (i.e., need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.
- II. All nursing staff will be in serviced on the facility's policy for physician and legal representative notification of change of condition. Additionally, in servicing will be conducted regarding notification of the Director of Nursing (DON) and/or designee on call after hours and on weekends regarding falls and resident change of condition to ensure thorough assessment and notification have been done to resident.
- III. All nursing staff will be in serviced on the facility's policy to assess for causative factors contributing to falls and take corrective actions based on said factors for those residents with a history of falls. The in servicing must also include the systemic changes to reasonably assure deficiency does not recur by review of protocol for safety interventions, monitoring, care planning and assessment.
- IV. The Director of Nursing (DON) and/or Clinical Nurse Leaders, will audit documentation in the medical record for compliance for compliance weekly for six (6) weeks and then quarterly in the Quality Assurance meetings. Audits with negative outcomes will result in further education for staff involved and/or possible disciplinary action.
 - V. Documentation of in-service training will be maintained by the facility.
- VI. The Administrator, Director of Nurses, and Quality Assurance Committee will monitor Items I through VI to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Seven (7) days from receipt of this Imposed Plan of Correction.